		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040584

Facility Name: Baptist Retirement Home

Address: 316 Randolph (Number) Maywood (City) 60153 (Zip Code)

County: Cook

Telephone Number: (708) 344-1541 **Fax #** ( )

IDPA ID Number: 36-2166967001

Date of Initial License for Current Owners:

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501c 3	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Deb Kotcher **Telephone Number:** (612) 253-1485

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 9/1/99 to 8/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Polly Schrom

(Title) Vice President of Finance

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Baptist Retirement Home # 0040584 Report Period Beginning: 9/1/99 Ending: 8/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	75	Intermediate (ICF)	75	27,450	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,450	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	12,811	11,221		24,032	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,811	11,221		24,032	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.55%

D. How many bed-hold days during this year were paid by Public Aid?
none (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/08/60

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 8/31/00 Fiscal Year: 8/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Baptist Retirement Home # 0040584 Report Period Beginning: 9/1/99 Ending: 8/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	134,099	15,268	325,369	474,736	(237,411)	237,325	(119,711)	117,614			1
2	Food Purchase		98,415		98,415	237,025	335,440	(119,711)	215,729			2
3	Housekeeping	150,763	7,875		158,638	(1,860)	156,778	(45,999)	110,779			3
4	Laundry	12,896	936	135	13,967	1,860	15,827	(4,644)	11,183			4
5	Heat and Other Utilities			149,150	149,150	3,788	152,938	(44,873)	108,065			5
6	Maintenance	44,925	11,948	164,272	221,145	1,039	222,184	(65,190)	156,994			6
7	Other (specify):*			6,343	6,343	2,002	8,345	(2,448)	5,897			7
8	**TOTAL General Services**	342,683	134,442	645,269	1,122,394	6,443	1,128,837	(402,576)	726,261			8
	B. Health Care and Programs											
9	Medical Director			7,950	7,950		7,950		7,950			9
10	Nursing and Medical Records	750,733	20,947	180,734	952,414		952,414	(9,839)	942,575			10
10a	Therapy											10a
11	Activities	32,303	7,176	1,856	41,335		41,335	(123)	41,212			11
12	Social Services	19,000		11,188	30,188		30,188		30,188			12
13	Nurse Aide Training											13
14	Program Transportation	533	44	42	619		619		619			14
15	Other (specify):*	35,675			35,675		35,675		35,675			15
16	**TOTAL Health Care and Programs**	838,244	28,167	201,770	1,068,181		1,068,181	(9,962)	1,058,219			16
	C. General Administration											
17	Administrative	83,307	5,056	150,372	238,735	(46,965)	191,770	714	192,484			17
18	Directors Fees											18
19	Professional Services			74,338	74,338		74,338		74,338			19
20	Dues, Fees, Subscriptions & Promotions			19,246	19,246	1,147	20,393		20,393			20
21	Clerical & General Office Expenses	69,823	5,456	16,032	91,311		91,311	(15,334)	75,977			21
22	Employee Benefits & Payroll Taxes			206,670	206,670	26,066	232,736	(20,827)	211,909			22
23	Inservice Training & Education			1,201	1,201		1,201		1,201			23
24	Travel and Seminar			4,297	4,297		4,297		4,297			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			27,092	27,092		27,092	(7,949)	19,143			26
27	Other (specify):*			73,690	73,690	6,926	80,616	4,326	84,942			27
28	**TOTAL General Administration**	153,130	10,512	572,938	736,580	(12,826)	723,754	(39,070)	684,684			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,334,057	173,121	1,419,977	2,927,155	(6,383)	2,920,772	(451,608)	2,469,164			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Baptist Retirement Home #0040584 Report Period Beginning: 9/1/99 Ending: 8/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			137,559	137,559	7,916	145,475	2,038	147,513			30
31	Amortization of Pre-Op. & Org.			4,037	4,037		4,037		4,037			31
32	Interest			87,645	87,645	(1,533)	86,112	(80,487)	5,625			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			229,241	229,241	6,383	235,624	(78,449)	157,175			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,526	51,526		51,526		51,526			42
43	Other (specify):*			443	443		443		443			43
44	**TOTAL Special Cost Centers**			51,969	51,969		51,969		51,969			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,334,057	173,121	1,701,187	3,208,365		3,208,365	(530,057)	2,678,308			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Baptist Retirement Home # 0040584 Report Period Beginning: 9/1/99 Ending: 8/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,396)	1/2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(7,588)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,038	30		9
10	Interest and Other Investment Income	(80,847)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(65)	21		15
16	Personal Expenses (Including Transportation)	(1,800)	17		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(9,702)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(125)			28
29	Other-Attach Schedule Independent Living	(512,323)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (612,808)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	78,515	17	34
35	Other- Attach Schedule	4,236		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 82,751		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (530,057)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Page 5A

Baptist Retirement Home

ID# 0040584

Report Period Beginning: 9/1/99

Ending: 8/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Baptist Retirement Home # 0040584 **Report Period Beginning:** 9/1/99 **Ending:** 8/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(7,588)	0	0	0	0	0	0	0	0	0	0	(7,588)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(7,588)	0	0	0	0	0	0	0	0	0	0	(7,588)	16
	C. General Administration													
17	Administrative	76,715	0	0	0	0	0	0	0	0	0	0	76,715	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(9,767)	0	0	0	0	0	0	0	0	0	0	(9,767)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	66,948	0	0	0	0	0	0	0	0	0	0	66,948	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	59,360	0	0	0	0	0	0	0	0	0	0	59,360	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Baptist Retirement Home # 0040584 **Report Period Beginning:** 9/1/99 **Ending:** 8/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,038	0	0	0	0	0	0	0	0	0	0	2,038	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(80,847)	0	0	0	0	0	0	0	0	0	0	(80,847)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(78,809)	0	0	0	0	0	0	0	0	0	0	(78,809)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(19,449)	0	0	0	0	0	0	0	0	0	0	(19,449)	45

Facility Name & ID Number Baptist Retirement Home # 0040584 Report Period Beginning: 9/1/99 Ending: 8/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
American Baptist Homes of the Midwest	100.00	Baptist Retirement Home	Maywood			
		See Attached Schedule				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			Management Fee	$ 150,372	American Baptist Homes of the Midwest	100.00%	$ 228,887	$ 78,515	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 150,372			$ 228,887	$ * 78,515	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Baptist Retirement Home # 0040584 Report Period Beginning: 9/1/99 Ending: 8/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	This is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Baptist Retirement Home # 0040584 Report Period Beginning: 9/1/99 Ending: 8/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: American Baptist Homes of the Midwest
Street Address: 11985 Technology Drive
City / State / Zip Code: Eden Prairie, MN 55344
Phone Number: (952) 941-3175
Fax Number: (952) 941-8567

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Mangement Fee	Days	483,899	18	$ 3,194,732	$ 1,319,890	34,669	$ 228,887	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,194,732	$ 1,319,890		$ 228,887	25

Facility Name & ID Number Baptist Retirement Home # 0040584 Report Period Beginning: 9/1/99 Ending: 8/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Banco Popular		X	Refinance Renovation	Yes	11/20/95	$ 1,600,000	$ 1,316,721	11/20/15	6.1300	$ 85,610	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,600,000	$ 1,316,721			$ 85,610	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,600,000	$ 1,316,721			$ 85,610	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Baptist Retirement Home # 0040584 **Report Period Beginning:** 9/1/99 **Ending:** 8/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Baptist Retirement Home # 0040584 Report Period Beginning: 9/1/99 Ending: 8/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,791 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1965	$ 31,966	1
2					2
3	TOTALS			$ 31,966	3

Facility Name & ID Number Baptist Retirement Home # 0040584 Report Period Beginning: 9/1/99 Ending: 8/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	75		1973	1973	$ 238,941	$ 4,799	50	$ 4,799	$	$ 131,150	4
5			1965	1965	233,438	4,669	50	4,669		165,466	5
6			1996	1996	495,474	19,819	25	19,819		79,276	6
7											7
8											8
	Improvement Type**										
9	Hand Rails			1978	938	19	50	19		421	9
10	Sprinkler System			1982	76,614	1,532	50	1,532		28,240	10
11	Lighting, Roof, Cabinets			1995	2,868	191	15	191		3,141	11
12	Air Cond, Fire Damper			1986	20,587	1,372	15	1,372		19,620	12
13	Roof Reconstruction			1987	4,715	314	15	314		4,220	13
14	Auto Door System			1992	2,516	168	15	168		1,413	14
15	Remodeling			1993	11,770	785	15	785		5,824	15
16	Roof			1997	36,400	1,820	20	1,820		13,508	16
17	Chair Lift			1993	3,427	228	15	228		1,695	17
18	First Floor Remodel			1993	28,045	1,402	20	1,402		10,407	18
19	Front Doors			1993	9,265	927	10	927		6,877	19
20	Carpeting			1993	3,824	382	10	382		2,837	20
21	Tub Refinishing			1993	260	32	5			260	21
22	Roof Replacement			1994	35,600	1,780	20	1,780		11,431	22
23	Driveway			1994	2,780	556	5			2,780	23
24	Carpeting			1994	696	70	10	70		448	24
25	Tuckpointing			1994	450	90	5			450	25
26	Kitchen Sink			1994	1,758	176	10	176		1,129	26
27	Boiler Repairs			1994	14,307	1,431	10	1,431		9,188	27
28	New Boiler			1994	12,900	1,290	10	1,290		7,528	28
29	Roof Repair			1994	23,300	1,165	20	1,165		6,798	29
30	New Boiler			1995	33,850	3,385	10	3,385		18,900	30
31	Land Improvements Acq			1995	3,250	163	20	163		976	31
32	Tank Removal			1995	6,094	305	20	305		1,829	32
33	Tank Removal Fill			1995	1,198	60	20	60		360	33
34	Final/Retainage			1996	36,303	3,025	12	3,025		11,785	34
35	Architectural Services			1996	10,697	891	12	891		3,465	35
36	TOTAL (lines 4 thru 35)				$ 1,352,265	$ 52,846		$ 52,168	$	$ 551,422	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Baptist Retirement Home # 0006569 Report Period Beginning: 9/1/98 Ending: 8/31/99

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	4 Trees			1996	1,500	75	20	75		300	9
10	Landscaping			1996	375	18	20	18		75	10
11	Various Improvements			1996	2,844	284	10	284		1,115	11
12	Door Closers			1997	262	10	25	10		41	12
13	Windows 4th Floor			1997	13,164	527	25	527		1,580	13
14	Reception Desk			1997	2,462	98	25	98		295	14
15	Chapel Floor			1997	2,839	114	25	114		341	15
16	Carport			1998	6,730	337	20	337		1,010	16
17	Tile Floor Lobby			1998	6,500	260	25	260		520	17
18	Carpet, Ceiling			1998	14,285	571	25	571		1,142	18
19	Windows SW Wing			1998	9,944	398	25	398		796	19
20	Windows SW Wing			1998	11,226	449	25	449		898	20
21	Install Windows			1998	4,283	171	25	171		342	21
22	Concrete Sidewalks			1998	5,000	250	20	250		250	22
23	Chaplains Office			1998	6,984	349	20	349		349	23
24	Concrete Steps			1999	2,400	120	20	120		120	24
25	Roof Repair			1999	2,275	114	20	114		114	25
26	Roof Repair			1999	2,520	126	20	126		126	26
27	Lock Replacement			2000	874	44	20	44	44	44	27
28	Lock Repair			2000	132	7	20	7	7	7	28
29	Electrical Circuits			2000	2,470	124	20	124	124	124	29
30	Laundry Room Plumbing			2000	6,014	301	20	301	301	301	30
31	Cooling Tower			2000	11,039	552	20	552	552	552	31
32	Cooling Tower Plumbing			2000	14,283	714	20	714	714	714	32
33	Chemtech Pump			2000	1,034	52	20	52	52	52	33
34	Cooling Tower Work			2000	4,880	244	20	244	244	244	34
35	Immaterial Adjustment										35
36	TOTAL (lines 4 thru 35)				$ 136,319	$ 6,308		$ 6,308	$ 2,038	$ 11,452	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Baptist Retirement Home # 0040584 Report Period Beginning: 9/1/99 Ending: 8/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 762,058	$ 79,402	$ 79,402	$	various	$ 230,951	37
38	Current Year Purchases	66,728						38
39	Fully Depreciated Assets	(35,598)	(9,888)	(9,888)				39
40								40
41	TOTALS	$ 793,188	$ 69,514	$ 69,514	$		$ 230,951	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,177,419	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 122,360	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 121,682	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 2,038	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 782,373	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Baptist Retirement Home # 0040584 Report Period Beginning: 9/1/99 Ending: 8/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Baptist Retirement Home **#** 0040584 **Report Period Beginning:** 9/1/99 **Ending:** 8/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 8/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,000	$	1
2	Cash-Patient Deposits	(256)		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	262,131		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	245,552		5
6	Prepaid Insurance	2,915		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 511,342	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	512,080		12
13	Land	44,500		13
14	Buildings, at Historical Cost	1,464,437		14
15	Leasehold Improvements, at Historical Cost	24,148		15
16	Equipment, at Historical Cost	794,671		16
17	Accumulated Depreciation (book methods)	(504,502)		17
18	Deferred Charges	61,564		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	20,495		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,417,393	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,928,735	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 10,721	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	53,063		29
30	Accrued Salaries Payable	78,389		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	7,009		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	21,134		35
	Other Current Liabilities(specify):			
36	**Inter Company Payable**	3,843,533		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,013,849	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,320,064		40
41	Bonds Payable			41
42	Deferred Compensation	32,754		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,352,818	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,366,667	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,437,932)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,928,735	$	48

***(See instructions.)**

Facility Name & ID Number Baptist Retirement Home # 0040584 Report Period Beginning: 9/1/99 Ending: 8/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,825,015)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,825,015)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(612,916)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (612,916)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,437,931)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Baptist Retirement Home # 0040584 Report Period Beginning: 9/1/99 Ending: 8/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,534,977	1
2	Discounts and Allowances for all Levels	(63,220)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,471,757	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,196	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,372	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,260	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	9,896	18
19	Laboratory	48,805	19
20	Radiology and X-Ray	10,635	20
21	Other Medical Services	123	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 76,287	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	55,307	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 55,307	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Legal Settlement	(4,326)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (4,326)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,599,025	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,128,837	31
32	Health Care	1,068,181	32
33	General Administration	727,330	33
	B. Capital Expense		
34	Ownership	235,624	34
	C. Ancillary Expense		
35	Special Cost Centers	51,969	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,211,941	40
41	**Income before Income Taxes (line 30 minus line 40)****	(612,916)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (612,916)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,466	1,626	$ 46,100	$ 28.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,911	1,963	37,802	19.26	3
4	Licensed Practical Nurses	11,844	13,350	201,383	15.08	4
5	Nurse Aides & Orderlies	49,465	53,992	435,765	8.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,966	2,098	20,401	9.72	9
10	Activity Assistants	1,481	1,529	11,780	7.70	10
11	Social Service Workers	1,081	1,141	19,000	16.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,917	17,560	130,314	7.42	15
16	Dishwashers					16
17	Maintenance Workers	4,235	4,584	44,608	9.73	17
18	Housekeepers	18,919	20,779	151,011	7.27	18
19	Laundry	1,767	1,861	12,749	6.85	19
20	Administrator	1,974	2,098	83,308	39.71	20
21	Assistant Administrator					21
22	Other Administrative	7,276	7,870	85,125	10.82	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Ward clerk	2,353	2,475	20,670	8.35	32
33	Other(specify) Marketing	2,038	2,098	35,713	17.02	33
34	TOTAL (lines 1 - 33)	124,693	135,024	$ 1,335,729 *	$ 9.89	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	11	677	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	448	11,188	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	459	$ 11,865		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	44	$ 2,284	10.3	50
51	Licensed Practical Nurses	3,083	95,190	10.3	51
52	Nurse Aides	514	9,685	10.3	52
53	TOTAL (lines 50 - 52)	3,641	$ 107,159		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karolee Coppoc	Administrator	None	$ 83,307
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,307

B. Administrative - Other

Description	Amount
Mangement Fee	$ 150,372
TOTAL (agree to Schedule V, line 17, col. 3)	$ 150,372
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See attached schedule		$ 23,041
		51,297
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 74,338

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,704
Unemployment Compensation Insurance	264
FICA Taxes	101,871
Employee Health Insurance	23,874
Employee Meals	386
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	135
Dental Insurance	229
Defered Compensation	32,186
Annuities/403B	3,808
Union Dues/Flex Plan/Employee Recognition	(4,787)
Allocation of Management Fee	26,066
Independent Living Adjust Off	(20,827)
TOTAL (agree to Schedule V, line 22, col.8)	$ 211,909

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Membership Dues	5,168
Licenses and Permits	575
Subscriptions	183
Computer Fees	6,743
Allocation of Management Fee	1,147
Bank/Investment Fees	6,577
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,393

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 614
In-State Travel	3,374
Seminar Expense	310
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,297

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Baptist Retirement Home # 0040584 Report Period Beginning: 9/1/99 Ending: 8/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? yes LPN

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network $3,372

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 8

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. 164$3 Diaper/$5321 Pads Line 10.2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 51,526
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 386 Has any meal income been offset against related costs? Yes Indicate the amount. $ 172

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 50%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.